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In the Supreme Court of the United States

OCTOBER TERM, 1992

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

MT. DIABLO HOSPITAL MEDICAL CENTER

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KENNETH W. STARR
Solicitor General

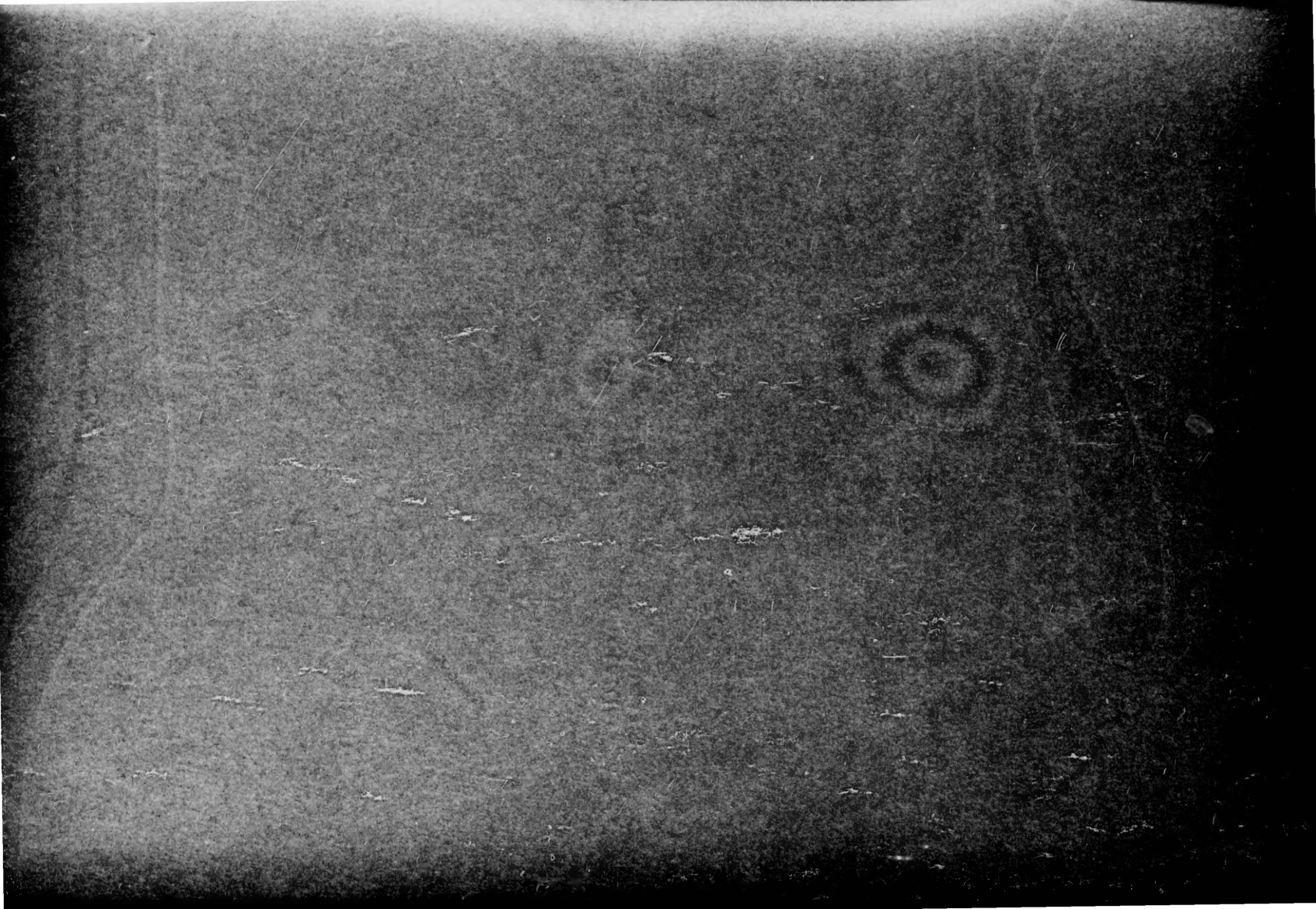
STUART M. GERSON
Assistant Attorney General

EDWIN S. KNEEDLER
Assistant to the Solicitor General

ROBERT A. LONG, JR.
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys
Department of Justice
Washington, D.C. 20530
(202) 514-2217

BEST AVAILABLE COPY



QUESTION PRESENTED

Under the Medicare program, health care providers are reimbursed by the government for expenses incurred in providing medical services to Medicare beneficiaries. Under Part A of the Medicare program, certain providers are reimbursed for the "customary charge" for services provided or the "reasonable cost" of the services, whichever is less. Congress has granted the Secretary authority to adopt methods for determining costs and to establish cost limits. 42 U.S.C. 1395x(v)(1)(A). Congress has also directed the Secretary to promulgate regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) (clause (ii)). The Secretary has promulgated regulations providing for exceptions to and exemptions from the cost limits in specified circumstances. The question presented is:

Whether a health care provider may obtain additional reimbursement under clause (ii) in excess of the cost limits established by the Secretary even if the provider does not qualify for an exception or exemption under the Secretary's regulations.

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In the Supreme Court of the United States

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No.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

MT. DIABLO HOSPITAL MEDICAL CENTER

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-19a) is reported at 963 F.2d 1175. The opinion of the district court (App., *infra*, 24a-39a) and the decision of the Provider Reimbursement Review Board (App., *infra*, 21a-23a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 28, 1992. A petition for rehearing was denied on July 24, 1992. App., *infra*, 20a. The juris-

diction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISION INVOLVED

Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), is reproduced at App., *infra*, 40a-41a.

STATEMENT

1. a. The Medicare program provides for payment of medical expenses for eligible aged and disabled persons. See 42 U.S.C. 1395 *et seq.* Part A of the Medicare program authorizes payment for primary institutional care to providers of services, including hospitals, skilled nursing facilities, and home health agencies. See 42 U.S.C. 1395c to 1395i-3 (1988 & Supp. II 1990).

For the years at issue in this case, Part A providers were reimbursed for the "customary charge" for the services furnished or the "reasonable cost" of the services, whichever was less. See 42 U.S.C. 1395f(b)(1).[1] The Medicare statute defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and directs the Secretary to promulgate regulations establishing methods for determining reasonable cost. 42 U.S.C. 1395x(v)(1)(A). The statute also directs the Secretary to promulgate regulations that "provide for the making of suitable retroactive

[1] Beginning October 1, 1983, most Part A Medicare claims for hospital inpatient services are reimbursed in accordance with prospectively determined rates under the Prospective Payment System. See 42 U.S.C. 1395ww(d) (1988 & Supp. II 1990); 42 C.F.R. Pt. 412 (1991).

corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) [hereinafter "clause (ii)"].

Congress became concerned that, in practice, the system of reimbursing providers for their "reasonable cost" allowed providers to recover whatever costs they incurred. H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-85 (1971); S. Rep. No. 1230, 92d Cong, 2d Sess. 188-189 (1972). In 1972, Congress responded to this problem by authorizing the Secretary to promulgate regulations establishing cost limits that would "be recognized as reasonable." Social Security Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1393-1394. In 1974, the Secretary promulgated regulations establishing cost limits for certain items and services furnished by providers. See 20 C.F.R. 405.460 (1975), redesignated as 42 C.F.R. 413.30 (1991). The regulations establish a presumption that reimbursable costs may not exceed the applicable limits. 42 C.F.R. 413.30(a)(2) (1991). The regulations also specify the circumstances in which a provider may obtain reimbursement in excess of the applicable cost limits. Exemption from the cost limits may be granted to certain providers, such as new providers, sole community hospitals, and small rural hospitals. 42 C.F.R. 413.30(e) (1991). In addition, exceptions may be granted in certain situations, such as those involving atypical services, extraordinary circumstances beyond the provider's control, or essential community hospital services. 42 C.F.R. 413.30 (f)(1991).

b. In 1979, the Secretary adopted, as part of the cost limits, a "wage index" to "adjust[] for variations in wage levels" in different geographical areas. 44 Fed. Reg. 11,613 (1979). Initially, the Secretary relied on wage data from the Bureau of Labor Statistics (BLS). *Ibid.* The BLS data were criticized because, among other things, they failed to account for local variations in the proportion of part-time to full-time workers.

In 1984, Congress directed the Secretary to conduct a wage index study to adjust for variations in part-time employees. See Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081. Based on data obtained from that study, the Secretary revised the wage index in 1986 to account for part-time employees. 51 Fed. Reg. 16,772 (1986). Congress provided that the revised index would be applicable only to patient discharges occurring on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156.

2. a. Respondent is a Medicare provider that exceeded the Secretary's cost limits for fiscal years 1982 and 1983. Pet. App. 27a. Respondent did not claim an exemption from the cost limits, nor did it claim that it was entitled to an exception to those limits under the Secretary's regulations. Instead, respondent contended that it was entitled to (1) an upward revision of the wage index for the years at issue in light of the Secretary's 1986 wage index revision, or (2) a "retroactive corrective adjustment" in reimbursement under clause (ii), as interpreted in *Regents of the Univ. of California* v. *Heckler*, 771 F.2d

1182, 1188-1192 (9th Cir. 1985). Pet. App. 6a. In *Regents*, the court of appeals held that the Secretary had a "statutory obligation" to reimburse providers for all costs claimed as "reasonable," even if those costs exceeded the cost limits and did not fall within a recognized exception or exemption. *Ibid.*

The Provider Reimbursement Review Board determined that it lacked authority over respondent's legal claims. Accordingly, the Board granted respondent's request for expedited judicial review. App., *infra*, 21a-23a; see 42 U.S.C. 1395*oo*(f)(1).

b. The district court entered summary judgment for petitioner. App., *infra*, 24a-39a. It concluded that "the Secretary's use of the BLS wage index as part of a nationwide system for calculating reimbursement cost limits was reasonable." *Id.* at 30a. In addition, the court rejected respondent's argument that it was entitled to a "retroactive corrective adjustment" under clause (ii). The court concluded that the Ninth Circuit's decision in *Regents* is "no longer viable" in light of this Court's intervening decision in *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). App., *infra*, 35a. The court also found respondent's argument to be inconsistent with the plain language of clause (ii), which provides for making retroactive corrective adjustments only pursuant to regulations promulgated by the Secretary. *Id.* at 37a n.6. Finally, the court concluded that respondent's interpretation of clause (ii) is inconsistent with the statutory framework, because it would create "an extraordinarily inefficient and essentially unworkable process for determining the definition of 'reasonable costs.'" *Id.* at 37a.

3. The court of appeals reversed. App., *infra*, 1a-20a.[2] It agreed with the district court that "the Secretary acted reasonably in formulating the wage index," *id.* at 13a, and rejected respondent's arguments that the Secretary failed to consider relevant factors and to respond adequately to public comments. *Id.* at 7a-14a. But the court of appeals held that clause (ii) "entitled [respondent] to make a showing that [its] compensation was inadequate and that [it is] entitled to a retroactive adjustment awarding * * * [all] 'reasonable' costs in excess of the limits prescribed by the Secretary." *Id.* at 18a.

The court of appeals stated that "[t]he only question * * * is whether *Regents* remains good law after the * * * decision in *Bowen* v. *Georgetown University Hospital*." App., *infra*, 15a-16a. The court answered that question in the affirmative, reasoning that "the rule established * * * in *Georgetown* is that case-by-case adjustments in the interests of justice are allowed under clause (ii), but rules of general applicability are not." *Id.* at 17a. The court concluded that respondent was "seeking [an] individualized adjustment[] to the aggregrate amount of [its] reimbursement * * *, not revisions in the cost methods used by the Secretary." *Id.* at 11a. Consequently, the court held that respondent had a right to make a showing that it "was entitled to a retroactive adjustment awarding [respondent its] 'reasonable' costs in excess of the limits prescribed by the Secretary." *Id.* at 18a. The court "*expressly* rejected" the contrary

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[2] The court of appeals affirmed a judgment in favor of the Secretary in a separate case involving other hospitals, *Memorial Hospitals Ass'n* v. *Bowen*, No. 90-15857. See App., *infra*, 18a-19a. That ruling is not at issue in this petition.

holdings of the Eighth and District of Columbia Circuits that clause (ii) merely allows for a "year-end book balancing" of the amounts owed between a provider and the Secretary. App., *infra*, 18a n.9 (citing *Good Samaritan Hosp.* v. *Sullivan*, 952 F.2d 1017 (8th Cir. 1991), cert. granted, No. 91-2079 (Oct. 13, 1992); *Hennepin County* v. *Sullivan*, 883 F.2d 85 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990)).

REASONS FOR GRANTING THE PETITION

On October 13, 1992, this Court granted the petition for a writ of certiorari in *Good Samaritan Hosp.* v. *Sullivan*, No. 91-2079. Like respondent here, the petitioners in *Good Samaritan* sought reimbursement under clause (ii) for costs that exceeded the Secretary's cost limits. The Eighth Circuit, relying on this Court's decision in *Bowen* v. *Georgetown Univ. Hosp.*, *supra*, held that "clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts." 952 F.2d at 1024. Accordingly, the court held that clause (ii) "merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Ibid.* See also *Hennepin County* v. *Sullivan*, 883 F.2d at 93 (clause (ii) "does not authorize a post hoc reassessment of the efficacy of the relevant standard, only of the calculations made pursuant to that standard").

This case poses the same question presented in *Good Samaritan*.* As framed by petitioners, the principal question presented in *Good Samaritan* is whether

> the case-by-case adjustments required under clause (ii) [are] limited to year-end book-

> balancing to reconcile interim payments received during the year with the amounts due under the regulatory methods for determining reasonable cost, as the Eighth and D.C. Circuits have held, or must * * * include substantive adjustments to an individual provider's reimbursement when the regulatory methods themselves result in inadequate or excessive reimbursement, as the Ninth Circuit has held.

91-2079 Pet. at i. As the *Good Samaritan* petitioners explain (*id.* at 9-10), the Eighth Circuit's decision in this case conflicts with the Ninth Circuit's decision here. Indeed, the Ninth Circuit acknowledged that its decision in this case conflicts with *Good Samaritan*, as well as with the D.C. Circuit's decision in *Hennepin County*. See App., *infra*, 18a n.9. Because this Court's decision in *Good Samaritan* may control the outcome of this case, the Court should hold the petition in this case and then dispose of it as appropriate in light of its decision in *Good Samaritan*.

CONCLUSION

The petition for a writ of certiorari should be held pending the Court's decision in *Good Samaritan Hosp.* v. *Sullivan*, cert. granted, No. 91-2079 (Oct. 13, 1992), and then disposed of as appropriate in light of that decision.

Respectfully submitted.

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

EDWIN S. KNEEDLER
Assistant to the Solicitor General

ROBERT A. LONG, JR.
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys

OCTOBER 1992

APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15772

D.C. No. CV 89-2714-DLJ

MT. DIABLO HOSPITAL, PLAINTIFF-APPELLANT

v.

LOUIS W. SULLIVAN, M.D., Secretary of Health and Human Services, DEFENDANT-APPELLEE

Appeal from the United States District Court
for the Northern District of California
D. Lowell Jensen, District Judge, Presiding

No. 90-15857

D.C. No. CV 88-282-EDP

MEMORIAL HOSPITALS ASSOCIATION,
PLAINTIFF-APPELLANT

v.

OTIS R. BOWEN, M.D., Secretary of Health and Human Services, DEFENDANT-APPELLEE

Appeal from the United States District Court
for the Eastern District of California
Edward D. Price, District Judge, Presiding

Argued and Submitted
August 20, 1991—San Francisco, California

Filed April 28, 1992

Before: Dorothy W. Nelson, Cynthia Holcomb Hall, and Ferdinand F. Fernandez, Circuit Judges.

OPINION

PER CURIAM:

Mt. Diablo and Memorial Hospitals appeal from the district courts' grants of appellee Secretary of Health and Human Services Louis Sullivan's ("Secretary") motions for summary judgment. We consider whether the district courts erred in concluding (1) that the Secretary's methods for determining routine cost limits for Medicare reimbursement are not arbitrary and capricious and (2) that the providers were not entitled to retroactive corrective adjustments to compensate them for the effects of those cost limits. For the reasons stated below, we affirm the judgment in *Memorial Hospitals v. Sullivan*, No. 90-15857, but reverse and remand the decision in *Mt. Diablo Hospital v. Sullivan*, No. 90-15772.

I

BACKGROUND

Appellants provide health care services to eligible aged and disabled persons under the Medicare program, 42 U.S.C. § 1395 et seq. For the cost years at issue in this case,[1] providers were reimbursed for

[1] Memorial challenges the reimbursement it received for the fiscal year ending in 1980. Mt. Diablo challenges its reimbursement for the fiscal years ending in 1982 and 1983.

daily routine service costs at a rate equivalent to the lesser of the "reasonable cost" of the services or the "customary charges" for the services. Appellants challenge the methods used by the Secretary to determine the "reasonable cost" of providing routine care.

In 1972, Congress amended the Medicare Act to give the Secretary broad discretion to define reasonable costs.[2] The amendments were motivated by the desire to contain costs arising from "variations in the efficiency of operation [and] the provision of amenities in plush surroundings." H.R. Rep. No. 231, 92nd Cong., 2d Sess., *reprinted in* 1972 U.S.C.C.A.N. 4989, 5069 [hereinafter ,House Report]. Previously providers had been reimbursed for their actual incurred costs. The new regulations excluded "any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . ." 42 U.S.C. § 1395x(v)(1)(A).

In 1974, the Secretary began the yearly publication of a schedule of routine cost limits pursuant to the 1972 amendments. The schedules were based on fac-

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[2] 42 U.S.C. § 1395x(v)(1)(A) states:

> Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs.

tors the Secretary found "appropriate and practical," including types of services furnished, geographic area, and institutional size. The schedules categorized hospitals by the per capita income of the location area and by number of beds. In 1979, the Secretary began using a wage index to calculate the reasonable cost of labor. The index was based on reports of quarterly hospital wages made to the Bureau of Labor Statistics of the Department of Labor ("BLS"). The average wage for a geographic area was computed by dividing the total hospital wages paid in one year by the total number of hospital workers in the area. The index was then formulated by dividing the average local wage by the national average. The resulting index value for each area would reflect the wage level for that area relative to the national average. *See Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981*, 46 Fed. Reg. 33637, 33638-89 (June 30, 1981) [hereinafter *1981 Schedule of Limits*].

The BLS data was criticized for several perceived flaws, including its age and its failure to standardize for factors such as the variation in occupational mix and proportion of part-time workers. The data's effective assumption that all employees worked full-time was detrimental to areas that employed large numbers of part-time workers. Areas in which hospitals employed large numbers of part-time employees were determined to have lower costs per employee, and consequently assigned lower index values, than areas in which hospitals had the same costs but a different mix of part-time and full-time workers. Commentators also noted a distorting effect from the inclusion of

federal and state hospital wage data in the index. The Secretary defended the use of the BLS data, stating that the indices employed "the most reliable data available." *Health Care Financing Administration Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1980*, 45 Fed. Reg. 41868, 41871 (June 20, 1980).

In 1983, Congress ordered the Secretary to conduct a study to develop a wage index that accounted for the deficiencies in the BLS data. According to the Secretary, the group which eventually conducted the study concluded that the failure to account for part-time workers was the "most serious deficiency" in the BLS data. In 1986, the Secretary finally revised the index to distinguish between part-time and full-time employees.

For the cost years at issue in this case, which were governed by the pre-1986 indices, appellants' costs exceeded the routine cost limits. Each appealed to the Provider Reimbursement Review Board ("PRRB") as required under the Medicare Act, 42 U.S.C. § 1395oo(a). Memorial sought reimbursement for costs in excess of Medicare's routine cost limits. Mt. Diablo requested an order allowing it to go directly to federal court to challenge the cost limits. The PRRB determined that it had no power to determine the validity of the wage index and authorized the parties to seek judicial review in the district court under 42 U.S.C. § 1395oo(f)(1).

Memorial and Mt. Diablo filed suit in the district courts in May 1988 and July 1989, respectively. Memorial sought a retroactive corrective adjustment to its reimbursement based on the "errors" in the wage index or, alternatively, an exemption from the routine

cost limits on the grounds that the inaccurate wage index was "an extraordinary circumstance beyond its control."[3] Mt. Diablo sought both a declaration that the methodology used in calculating the area wage index was invalid and a retroactive corrective adjustment. The district courts granted the Secretary's motions for summary judgment in each case. Both hospitals timely appealed.

II

STANDARD OF REVIEW

We review the district court's grant of the Secretary's motion for summary judgement de novo. *Vallejo Gen. Hosp. v. Bowen*, 851 F.2d 229, 230-31 (9th Cir. 1988).

The Secretary's Medicare reimbursement policy is reviewed under the Administrative Procedure Act (APA). 42 U.S.C. § 1395oo(f)(1). Under the APA, we must determine if the Secretary's action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). In making this determination, we

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[3] There are two basic mechanisms for the adjustment of cost limits where the general rules do not adequately reimburse the health care provider for its reasonable costs—exemptions and retroactive corrective adjustments. An exemption may be granted where, for example, excess expenses are attributable to provision of atypical services or "extraordinary circumstances." It will be allowed "only if the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the [the fiscal agent of the Secretary]." *Hennepin County v. Sullivan*, 883 F.2d 85, 87 (D.C. Cir. 1989), *cert. denied*, 493 U.S. 1043 (1990); 42 C.F.R. § 413.30(e), (f). Memorial does not appeal the denial of its request for an exemption.

"must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971).

III

ANALYSIS

A. Calculation of Cost Limits

Mt. Diablo argues that the pre-1986 method for calculating routine cost limits was arbitrary and capricious for two reasons. First, they contend that the Secretary ignored a relevant factor—the discrepancies in the wage index caused by regional variations in the use of part-time and full-time employees. Second, they argue that the Secretary failed to respond adequately to public comments on this issue.

1. Failure to consider a relevant factor.

Mt. Diablo points to three comments on the proposed use of the BLS data as evidence that the Secretary knew about and failed to consider the distortion caused by part-time workers.[4] In 1979, the Hospital

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[4] Mt. Diablo also points out that in the July 3, 1984, Federal Register the Secretary acknowledged that "the most serious deficiency" of the BLS data was its failure to control for part-time workers. *Health Care Financing Administration Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges on or After October 1, 1984, and Update Factors Effective with Cost Reporting Periods Beginning on or After October 1, 1984*, 49 Fed. Reg. 27438, 27439 (July 3, 1984). It relies upon the adoption in 1986 of a wage index accounting for part-time workers as further evidence of the rule's arbitrariness. Evidence of subsequent

Association of New York State (HANYS) commented: "A wage level comparison based upon [the BLS data relating to service workers] can be distorted by the regional variations in mix of part-time employment, hours worked per week, overtime pay, etc." *Comments of the Hospital Association of New York State on the Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning On Or After July 1, 1979*, April 30, 1979, at 2 [hereinafter *Comments of HANYS*].[5]

In 1980, the Secretary received two additional comments on the wage index. The Hospital Association of Rhode Island advocated use of data from the American Hospital Association (AHA) because of the distortion caused by BLS' failure to account for part-time workers. An accounting firm also noted the impact of the omission, stating that "those areas with a large volume of part-time hospital workers will rate lower than areas with more full-time employment, even though their actual wage scales may be higher."

We review agency actions under the APA to determine if the agency has adequately considered all

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developments, however, is not considered in a review of informal agency rulemaking. Review is limited to the administrative record before the Secretary at the time of his decision. *See Citizens to Preserve Overton Park*, 401 U.S. at 420.

[5] However, HANYS also acknowledged:

> [T]here is, at the present time, no data source which is external to the hospital economy that can be used to reasonably adjust the differences between salaries. The development of such data certainly is possible but would involve considerable time, difficulty, and expense to develop.

Comments of HANYS, at 2.

"relevant factors." *See Citizens to Preserve Overton Park*, 401 U.S. at 416. An agency rule may be found to be arbitrary and capricious when

> the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

We may conclude that an agency has ignored relevant factors where its action amounts to an " 'artificial narrowing of options' [which] is antithetical to reasoned decisionmaking . . . ." *International Ladies' Garment Workers Union v. Donovan*, 722 F.2d 795, 817 (D.C. Cir. 1983) (quoting *Pillai v. Civil Aeronautics Bd.*, 485 F.2d 1018, 1027 (D.C. Cir. 1973)) (internal citation omitted). Agency actions cannot be sustained where the agency has failed to consider significant alternatives. *See ILGWU*, 722 F.2d at 815-16 (agency failed to consider "substantial testimony" and "specific proposals" for alternative actions). Similarly, an action will not be upheld where the agency has intentionally omitted evidence from consideration or where there is nothing in the record to support the agency's decision. *See Pillai*, 485 F.2d at 1027; *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982) (in drafting documents supporting a proposal, agency intentionally omitted facts which undermined its position), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

Applying these criteria, we cannot conclude that the Secretary acted arbitrarily or capriciously by not factoring the use of part-time workers into the wage index. A relatively insignificant percentage of the comments received during the period leading up to the adoption of the 1981 routine cost limits were directed at the part-time worker issue. Most comments were directed at other concerns, particularly a fundamental change in the reimbursement rate and the proposed methods of classifying care providers. Additionally, the record suggests that, far from intentionally omitting the issue from consideration, the agency recognized the growing concern about the part-time worker issue and planned to address it in a comprehensive manner. Indeed, the agency proposed in 1981 to develop an appropriate database by modifying the Medicare cost report, but the proposal was delayed in part because of opposition from the hospital industry.

Moreover, the agency's action was well within the reasonable bounds of its Congressional mandate. The agency was given broad powers to promulgate regulations providing for the determination of the costs of services, including the establishment of limits on costs to be recognized as reasonable. *See* 42 U.S.C. § 1395x (v)(1)(A). A court must accord an agency's statutory interpretation "substantial deference," since "presumably [the agency] has brought its expertise to bear in formulating the regulation . . . ." *American Hosp. Mgmt. Corp. v. Harris*, 638 F.2d 1208, 1212 (9th Cir. 1981). Review in such a case "is limited to determining whether the regulation is reasonably related to the purpose of the relevant enabling legislation . . . ." *Id.*

Here, Congress recognized that "the initial ceilings will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. . . . The data that are availaole for this purpose will often be less than perfectly reliable . . . ." House Report, *supra*, at 5070. To forbid the agency from adopting routine cost limits until perfect data concerning a relatively minor issue is developed would contravene the agency's mandate. This is particularly true in the case of part-time workers, since Congress had recognized the need for ongoing refinements and the agency had proposed to remedy the problem.

Mt. Diablo also argues that the Secretary should have used AHA data, which was weighted to account for the part-time worker issue, in formulating the wage index. It claims this data was available to the Secretary as early as 1979, and that it was used in calculating other portions of the wage index.

The Secretary did not indicate why (or whether) the BLS data was preferable to the AHA data with regard to the part-time worker issue. But "we will uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974). That path is evident here. The record indicates that the decision to use the BLS data was based upon a number of factors, including variations in overtime, and variations in hospital occupational categories. The agency stated in the June 20, 1980, Federal Register that it did "not bas[e] the wage index on AHA data because these data are less complete than those supplied by the BLS, since they do not include all of the occupational categories comprised by the BLS data base."

Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs of Cost Reporting Periods Beginning on or after July 1, 1980, 45 Fed. Reg. 41868, 41872 (1980). The agency simply chose one imperfect database over another while seeking to develop data superior to either. This choice was rational. The Secretary concluded that the BLS data were "the most reliable data available" at the time. *See Schedule of Limits*, *supra* at 33639. Given the narrow scope of review, we cannot regard the Secretary's decision to use that data as arbitrary and capricious.[6]

2. Failure to respond adequately to public comments.

Mt. Diablo argues that the routine cost limits are invalid because the Secretary "did not respond specifically" in the Federal Register to comments about

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[6] The Eighth Circuit has reached the same conclusion on similar facts. In *Good Samaritan Hosp. v. Sullivan*, 952 F.2d 1017 (8th Cir. 1991), rural Nebraska hospitals, which exceeded the Secretary's cost schedules, claimed that the wage-index regulations were arbitrary and capricious for failing to account for the use of part-time employees. Like appellants in this case, the hospitals claimed that the Secretary knew of the distortion but did nothing to correct it. The Eighth Circuit rejected the hospitals' claim, holding:

> At the time the regulations were in place, the Secretary claims that they were based upon the latest available data. There is nothing arbitrary or capricious about the cost limit methodology used by the Secretary. Both the wage index and the rural/urban distinction were based on objective data and regulations, and we hold the SMSA-based cost limit regulations are not arbitrary or capricious.

Id. at 1025 (citations omitted).

the part-time worker issue. The Secretary explained his use of the BLS data only by saying that they were "the most reliable data available." *See Schedule of Limits*, *supra* at 33639. Mt. Diablo contends that the Secretary was obligated to explain the reasoning behind that conclusion.

A rule may be invalidated under the APA because an agency fails to explain the rule adequately. *United States v. Garner*, 767 F.2d 104, 117 (5th Cir. 1985); *see also International Bhd. of Teamsters v. United States*, 735 F.2d 1525, 1532 (D.C. Cir. 1984) (in absence of "*other* indication" of why the agency acted as it did, "bald assertion" that reporting items are "unnecessary" cannot be upheld). Nevertheless,

> [t]here is no obligation to make references in the agency explanation to all the specific issues raised in comments. The agency's explanation must simply enable a reviewing court to see what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them the way it did.

South Carolina ex rel. Tindal v. Block, 717 F.2d 874, 886 (4th Cir. 1983) (internal citations and quotations omitted), *cert. denied*, 465 U.S. 1080 (1984). In making the "keystone" inquiry whether the Secretary "engaged in reasoned decisionmaking," *ILGWU*, 722 F.2d at 815, the reviewing court is to consider the larger administrative record. 5 U.S.C. § 706.

As the preceding discussion explains, the record indicates that the Secretary acted reasonably in formulating the wage index. Moreover, given the fact that the part-time worker issue was of minor significance at the time the wage index was adopted, the Secretary had no obligation to provide a specific re-

sponse to the comments about it. The Secretary's general response to the concern over the validity of the BLS data was appropriate.

B. Retroactive Corrective Adjustments

The Medicare statute, 42 U.S.C. § 1395, requires the Secretary to make "retroactive corrective adjustments" for hospitals whose reimbursement under the cost rules "proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii). Mt. Diablo and Memorial hospitals seek a retroactive corrective adjustment because they claim that the old cost rules under-compensated them by failing adequately to take into account their labor costs. The district courts denied relief on different grounds.

The statute at issue, 42 U.S.C. § 1395x(v)(1)(A), provides that "[t]he reasonable cost of any services . . . shall be determined in accordance with regulations establishing the method or methods to be used . . . in determining such costs. . . . Such regulations shall . . . (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." On its face, the plain language of the statute appears to require the Secretary to make a retroactive adjustment when its cost method produces an inequitable result in a particular case.

In *Regents of the Univ. of California v. Heckler*, 771 F.2d 1182, 1189 (9th Cir. 1985), the Secretary contended that this provision requires "no more than a year-end balancing of the books." *Id.* at 1189. We rejected that argument for four reasons. First,

such a limited reading was inconsistent with the plain language of the statute, which requires adjustments whenever a hospital's compensation is "inadequate or excessive," not merely when it has been calculated incorrectly. *Id.* at 1189-90. Second, a different section—42 U.S.C. § 1395(g)—already provides for a year-end adjustment to rectify accounting errors made in calculating the cost reimbursements. To read section 1395x(v)(1)(A)(ii) as requiring nothing more would make it redundant. *Regents*, 771 F.2d at 1189.

Third, the 1972 Medicare amendments, which established the cost methods at issue in *Regents* and here, "merely added another method of cost calculation to those already recognized as legitimate by the statute." *Id.* Prior methods had already been determined to be subject to the provisions for retroactive adjustment. To conclude that this new method was immune from retroactive adjustments on the basis of inadequate reimbursement would lead to the perverse result of "render[ing] the corrective adjustment clause nugatory in the case of one particular method of calculating costs." *Id.* at 1190. Finally, *Regents* reviewed the legislative history of the section, which seemed unambiguously to establish that the Secretary's cost limits were *presumptive*, not conclusive. *Id.* Thus, *Regents* concluded that hospitals were entitled to seek a retroactive corrective adjustment on the grounds that the cost limits, *even though correctly applied*, worked an injustice in their particular circumstance. *Id.* at 1191.

Under *Regents*, the hospitals are entitled to make their case for a retroactive corrective adjustment. The only question in this case is whether *Regents* remains good law after the Supreme Court's deci-

sion in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988), which also applied section 1395x(v)(1)(A)(ii).

In *Georgetown*, the Secretary's 1981 cost rule had been struck down by a court, and the Secretary sought to reimpose the rule retroactively and collect the "overpayments" it had made to *all* hospitals during the time the rule had been held invalid. The Supreme Court rejected the Secretary's argument, holding:

> This provision [1395x(v)(1)(A)(ii)] on its face permits some form of retroactive action. We cannot accept the Secretary's argument, however, that it provides authority for the retroactive promulgation of cost-limit rules. To the contrary, we agree with the Court of Appeals that clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases. The structure and language of the statute require the conclusion that the retroactivity provision applies only to case-by-case adjudication, not to rulemaking.

Id. at 209. In so doing, *Georgetown* cited *Regents* with apparent approval, distinguishing it from those cases which had permitted the Secretary to engage in retroactive rulemaking. *Id.* at 209-10 n.1.[7]

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[7] Regarding *Regents*, the Supreme Court had this to say: "Other courts, without deciding whether clause (ii) permits rulemaking, have held that it requires the Secretary to make case-by-case adjustments to reimbursement determinations. *E.g.*, . . . *Regents of the University of California v. Heckler*,

Thus, the rule established by the Supreme Court in *Georgetown* is that case-by-case adjustments in the interests of justice are allowed under clause (ii), but rules of general applicability are not. The only question, therefore, is whether what Mt. Diablo and Memorial are seeking constitutes across-the-board rulemaking or a case-by-case adjustment. It seems clear that they intended to seek the latter. In fact, the district courts in both cases recognized that the hospitals were seeking individualized adjustments to the aggregate amount of their reimbursement under clause (ii), not revisions in the cost methods used by the Secretary.[5]

The Secretary suggests that, notwithstanding the hospitals' characterization of their own claims, they really seek rulemaking changes. We do not agree. Unlike the Secretary's proposed changes in *Georgetown*, which would affect all hospitals under the rules, the adjustments sought by Mt. Diablo and Memorial would apply only to them. The situation of the hospitals is similar to the situation in *Regents*: the hospital there was entitled to seek reimbursement under clause (ii) over and above the cost limits imposed by the Secretary, even though its claims were based on exceptions the Secretary had already determined not to apply. *See Regents*, 771 F.2d at 1185-86. Both the facts of this case and Ninth Circuit

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771 F.2d 1182, 1188-89 (CA9 1985)." *Georgetown*, 488 U.S. at 210 n.1.

[5] Both hospitals *also* sought changes in the Secretary's cost methods; those claims are dealt with in Part III.A, *ante*. There is nothing in the Medicare statute which prohibits hospitals from seeking both a general change in the law and a specific adjustment for their particularized circumstances.

precedent suggest that what the hospitals are seeking here is a case-by-case adjustment, not retroactive rulemaking.[9]

We therefore conclude that the hospitals are entitled to make a showing that their compensation was inadequate and that they are entitled to a retroactive adjustment awarding them their "reasonable" costs in excess of the limits prescribed by the Secretary. We remand the Mt. Diablo case to the district court to permit Mt. Diablo to make the required showing.

We do not need to remand the Memorial case, however. The district court in that case did not decide that *Georgetown* overruled *Regents*, but rather concluded that Memorial had not made a factual showing sufficient to entitle it to relief under clause (ii) because it could not demonstrate that its costs were reasonable. Memorial did not challenge that finding before this court, except to argue that the fact that the Secretary subsequently changed the cost limits

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[9] The Eighth Circuit has concluded in a very similar case that what the hospitals are seeking really constitutes rulemaking. *Good Samaritan Hospital v. Sullivan*, 952 F.2d 1017, 1023-24 (8th Cir. 1991); *see also Hennepin County v. Sullivan*, 883 F.2d 85, 92-93 (D.C. Cir. 1989) (stating same in dictum; parties conceded the issue at oral argument), *cert.* denied, 493 U.S. 1043 (1990). However, the conclusion in both those cases was based on the determination that "clause (ii) merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Good Samaritan*, 952 F.2d at 1024; *see Hennepin*, 883 F.2d at 93 (clause (ii) allows only review of accounting calculations). As noted above, this Circuit has *expressly* rejected that view for a number of sound reasons, *see Regents*, 771 F.2d at 1189, and nothing in *Georgetown* even intimates that clause (ii) is merely an accounting provision.

automatically rendered its costs reasonable. We reject this argument for the reasons already discussed. The fact that under *Regents* hospitals *may* be entitled to retroactive adjustments does not absolve them of the responsibility of proving that they *are* entitled to such adjustments in any particular case.

IV

CONCLUSION

We conclude that the Secretary's method for calculating routine cost limits for Medicare reimbursement was not rendered arbitrary and capricious by the Secretary's failure to account for the use of part-time workers. We also conclude that hospitals are entitled to seek a retroactive adjustment to the wage index to account for the use of part-time workers. The decision of the district court in docket No. 90-15857, *Memorial Hospitals Ass'n v. Sullivan*, is AFFIRMED. The decision of the district court in docket No. 90-15772, *Mt. Diablo Hospital v. Sullivan*, is REVERSED and REMANDED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15772

D.C. No. CV 89-2714-DLJ

MT. DIABLO HOSPITAL, PLAINTIFF-APPELLANT

v.

LOUIS W. SULLIVAN, M.D., Secretary of Health and Human Services, DEFENDANT-APPELLEE

Filed July 24, 1992

Before: D.W. NELSON, HALL, and FERNANDEZ, Circuit Judges.

The members of the panel that decided this case voted unanimously to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. (Fed. R. App. P. 35.)

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

APPENDIX C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

JRB:89-5001
(x REF:85-411 and 85-412)

CERTIFIED MAIL

James Franklin Owens, Esquire
Hooper, Lundy & Bookman, Inc.
Fox Plaza, Suite 430
2121 Avenue of the Stars
Los Angeles, CA 90067-5010

Re: Mt. Diablo Medical Center—Modesto, Modesto, CA, Provider No. 05-0496, Case No. 89-5001, F Y E's—June 30, 1982 and 1983, Request for a Board Determination that It Lacks the Authority to Decide Whether the Wage Index Calculation Within the Routine Care Cost Limits Regulation is Valid.

This is in response to your letter of May 18, 1989, regulating the Provider Reimbursement Review Board (Board), pursuant to 42 U.S.C. § 1395oo(f)(1), to determine that it is without authority to decide the validity of the wage index calculation within the routine care cost limits (Sections 1861(v)(1)(A), 1861(v)(7)(B) and 1886(a) of the Social Security Act, as amended) and the regulation 42 CFR 413.30 (formerly 42 CFR 405.460). The above-cited statutory provision permits a provider which has requested and is entitled to a hearing before the Board, under 42

U.S.C. § 1395oo(a), to bypass the Board's hearing procedure and obtain judicial review of an issue involving a question of law or regulation where the Board determines that it is without authority to decide such question.

The Board has reviewed the submissions pertaining to the request for expedited judicial review and finds as follows:

1. That the Board has jurisdiction of the matter in that the Provider is otherwise entitled to a hearing before this Board under the provisions of Section 1878(a) of the Social Security Act;

2. That the Board is bound by the applicable existing Medicare law and regulations pursuant to 42 CFR 405.1867;

3. That there are no factual matters in dispute for resolution before the Board; and

4. That the Board is without authority to decide the question of whether the wage index calculation, determined under the provisions of 42 CFR 413.30 (formerly 42 CFR 405.460) and Sections 1861 (v)(1)(A), and 1861(v)(7)(B) and 1886(a) of the Social Security Act, is valid.

Accordingly, the Board finds that this case properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for expedited judicial review for the wage index calculation issue for the subject years. The Provider has 60 days from the date of receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

SALLY A. KIRKPATRICK
Board Member

Enclosure

Section 1878(f)(1) of the Social Security Act, as amended

cc: BC&BSA
BC of California

JRB/sdm

APPENDIX D

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-89-2714-DLJ

MT. DIABLO HOSPITAL MEDICAL CENTER, PLAINTIFF

v.

LOUIS SULLIVAN, Secretary of the Department of Health and Human Services, DEFENDANT

ORDER

Filed May 24, 1990

Entered in Civil Docket 5/30, 1990

The Court heard cross-motions for summary judgment in this action on May 9, 1990. Patric Hooper and James Franklin Owens of Hooper, Lundy & Bookman in Los Angeles, California, appeared for plaintiff. Marcia K. Sowles of the Department of Justice's Civil Division appeared for defendant.

The issue in this case is whether or not the Ninth Circuit's decision in *Regents of the Univ. of California (Davis) v. Heckler*, 771 F.2d 1182 (9th Cir. 1985), survives the Supreme Court's decision in *Bowen v. Georgetown Univ. Hospital*, 488 U.S. 204, 109 S.Ct. 468 (1988). The following analysis concludes that it does not. Consequently, the Court GRANTS summary judgment to defendant.

I.

Plaintiff Mt. Diablo Hospital Medical Center (hereinafter "Mt. Diablo") is an acute care hospital which participates as a "provider" of Medicare services under the Medicare Act, 42 U.S.C. section 1395 *et seq.* Defendant Secretary of Health and Human Services ("the Secretary") administers the Medicare program, including the reimbursement of providers for the "reasonable cost" or "customary charges" for services furnished to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). This action stems from Mt. Diablo's contention that the Secretary did not adequately reimburse Mt. Diablo for the reasonable costs it incurred in furnishing Medicare benefits in fiscal years 1982 and 1983.

The Medicare Act specifically requires the Secretary to develop, by regulation, a nationwide system for establishing reasonable costs. 42 U.S.C. § 1395x(v)(1)(A). Pursuant to this authority, the Secretary may base reimbursement cost limits on, among other things, estimates of costs. *Id.*[1] In 1974 the Secretary promulgated regulations which set specific

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[1] The Act specifically provides that the Secretary's regulations

> may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall costs or incurred cost of specific items or services or group of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services. . . .

42 U.S.C. § 1395x(v)(1)(A).

reimbursement cost limits on certain items and services furnished by providers. *See* 39 Fed. Reg. 20,164 (June 6, 1974), *adding* 42 C.F.R. § 403.460, *redesignated as* 42 C.F.R. § 413.30. The Secretary also established enumerated bases and procedures through which providers could rebut the presumptive applicability of the cost limits by demonstrating their entitlement to an exception from the limits. 42 C.F.R. § 413.30(f).

Pursuant to 42 C.F.R. § 413.30, the Secretary began issuing annual schedules of reimbursement cost limits in 1974, categorizing hospitals based on geographical location, per capita income for the region, and bed size. Effective June 1, 1979, the Secretary changed the manner of calculating the cost limits by using an "area wage index" in place of per capita income to adjust, area by area, that portion of the national cost limit attributable to wages.[2] The Secretary developed the area wage index from data supplied by the Bureau of Labor Statistics ("BLS"). This data provided information on the number of workers employed at a given hospital, but did not distinguish between part-time and full-time employees. The Secretary's wage index therefore could not control for area differences in hospital use of part-time employees.

Using the above-described methods and data, the Secretary calculated the routine cost limit applicable to Mt. Diablo in fiscal year 1982 at $180.98. Accordingly, in fiscal year 1982 Mt. Diablo received a maxi-

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[2] The Secretary implemented the area wage index following a notice and public comment period of three months. *See* 44 Fed. Reg. 11,612 (March 1, 1979); 44 Fed. Reg. 31,806 (June 1, 1979).

mum of $180.98 for each day of routine care it provided to a Medicare beneficiary. In fiscal year 1983, the Medicare routine cost limit for Mt. Diablo increased to $194.72. The 1982 and 1983 cost limit figures derived from an area wage index adjustment of 1.3153, which reflected the Secretary's determination that during these years hospital labor costs in Mt. Diablo's metropolitan area were 31.53 percent greater than the national average of such costs.

Mt. Diablo's billings for services furnished to Medicare beneficiaries exceeded the Secretary's routine cost limits in 1982 and 1983, and consequently Mt. Diablo experienced a significant shortfall in Medicare reimbursement. Mt. Diablo attributes this loss of reimbursement funds to the Secretary's use of an imprecise area wage index to calculate the cost limit applied to Mt. Diablo's charges. It is undisputed that the Secretary's area wage index in 1982 and 1983 failed to account for variations in hospital use of part-time workers. Acting under a Congressional mandate, the Secretary in 1984 began to create a database specifically designed to overcome the technical limitations of the BLS data. The new data enabled the Secretary in 1986 to adopt a new wage index that controlled for area differences in the utilization of part-time employees. Under the revised methodology for determining the area wage index, Mt. Diablo's wage index adjustment rose 16.3 percent to 1.4783. However, Congress determined that the improved area wage index adjustment would be applied prospectively only.

Mt. Diablo brings this action for additional reimbursement from defendant's Medicare program for its 1982 and 1983 cost years, on grounds that the Secretary used a flawed area wage index to calculate

Medicare reimbursement during these years. Prior to bringing this action, Mt. Diablo properly sought and obtained an order for expedited judicial review from the Provider Reimbursement Review Board in connection with its 1982 and 1983 cost claims.

II.

Judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure Act, which requires this Court to set aside agency actions found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. . . ." 5 U.S.C. § 706(2)(A). At the same time, an agency's interpretation of a statute is merely influential and not binding upon courts when the "agency's decision is premised on its understanding of a specific congressional intent," because this implicates "the quintessential judicial function of deciding what a statute means." *Bureau of Alcohol, Tobacco & Firearms v. Federal Labor Relations Auth.*, 464 U.S. 89, 98 n.8 (1983). Thus, a reviewing court "must reject administrative constructions of [a] statute, whether reached by adjudication or by rulemaking, that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Securities Indus. Ass'n v. Board of Governors*, 468 U.S. 137, 143 (1984).

A. *The Reimbursement Cost Limits of 1982 and 1983.*

The Medicare Act specifically requires the Secretary to develop, by regulation, a nationwide system for establishing reasonable costs. 42 U.S.C. § 1395x(v)(1)(A). Pursuant to this authority, the Secre-

tary may base such cost limits on, among other things, estimates of costs. *Id.* Mt. Diablo contends that the 1979 rule underpinning the Secretary's area wage index for 1982 and 1983 was invalid under the Administrative Procedure Act, because the BLS wage index failed to account for variations in the use of part-time workers among hospitals.

Mt. Diablo challenges the validity of the BLS wage index on the following specific grounds: (1) The Secretary erred by ignoring a relevant factor, namely the variations in the use of part-time workers; (2) The Secretary relied on inferior BLS data in formulating the area wage index, when superior data was available from the American Hospital Association ("AHA") that included adjustments for part-time employees; (3) The Secretary knew that the area wage index was flawed as early as 1979 but did nothing to ameliorate the problem until required to do so by Congress; and (4) the Secretary's continued use of the BLS wage index after its adoption in 1979 was procedurally flawed because the Secretary did not engage in a dialogue with hospitals regarding the distortion of cost limits caused by part-time employees until 1984.

The Court finds these arguments by Mt. Diablo unpersuasive. Mt. Diablo in essence urges this Court to require the Secretary to account for all relevant factors in his area wage index adjustment, or else find the rule underpinning the area wage index invalid. The Court declines to adopt such a severe test. While it may be true that the 1982 and 1983 area wage index did not control for a relevant factor, the issue is not whether the cost limits were precise measures of Mt. Diablo's actual costs, or whether the data used by the Secretary to develop the cost limits

was free from flaws. Rather, the issue is whether the Secretary's use of the BLS wage index as part of a nationwide system for calculating reimbursement cost limits was reasonable.

The record in this case establishes that the Department of Health and Human Services adopted the challenged wage index based upon the best data available at the time. The AHA data referred to by Mt. Diablo did not include all occupational categories, and therefore was not used by the Secretary. The Court also rejects Mt. Diablo's contention that the Secretary's eventual calculation of the area wage index based upon area differences in use of part-time employees undermines the validity of the pre-existing wage index. The Court's analysis must focus on what information was available to the Secretary in 1979 when the BLS wage index was incorporated into the reimbursement cost limits calculation. To penalize the Secretary for subsequent modifications of existing rules would severely impede continual agency efforts to improve its procedures and regulations. *City of Austin, Texas, Brackenridge Hospital v. Heckler*, 753 F.2d 1307, 1315-16 (5th Cir. 1985). The Court declines the opportunity to invoke hindsight in such an improvident manner.

Mt. Diablo alternatively contends that even if using the best data available, the Secretary could not reasonably impose what he knew to be flawed estimated cost limits upon hospitals indefinitely. Under this theory, the Secretary has an affirmative duty to not only use the best data available, but also to seek better sources of data. The record here shows that the Secretary first became aware in 1979 of distortions in the area wage index caused by variations among hospitals in their use of part-time workers. By 1984,

the Secretary had taken significant affirmative steps to correct the problem. Mt. Diablo has failed to demonstrate that the delay from 1979 to 1984 in developing improved data was unreasonable. Nor has Mt. Diablo demonstrated that the Secretary failed to follow proper procedures in modifying the area wage index to account for hospital use of part-time labor.

For the foregoing reasons, the Court holds that Mt. Diablo has not carried its burden of demonstrating that the Secretary's actions in promulgating the Medicare reimbursement cost limits rule, or by adjusting the national cost limits in 1982 and 1983 by using an area wage index, were arbitrary or capricious.

B. Adjustment from the Cost Limits under Clause (ii).

The more difficult question in this case is presented by Mt. Diablo's contention that it is entitled to a "retroactive corrective adjustment" from the cost limits imposed upon it by the Secretary in 1982 and 1983, pursuant to 42 U.S.C. § 1395x(v)(1)(A)(ii) (hereinafter "clause (ii)"). Clause (ii) of the Medicare Act requires the Secretary to promulgate regulations that

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395x(v)(1)(A)(ii).

The Secretary has maintained in other cases that clause (ii) merely requires a year-end balancing of

the books, such that the actual amount of reimbursement paid to a provider such as Mt. Diablo in a given year coincides with the aggregate amount due it based based on the Secretary's previous estimate of reasonable costs.[3] In contrast, Mt. Diablo interprets clause (ii) as being more substantive. According to Mt. Diablo, clause (ii) authorizes retroactive corrective adjustments whenever necessary to correct flaws in the Secretary's cost limits for a particular provider. Under this interpretation, the Secretary's annual schedule of reimbursement cost limits is merely presumptive; each provider may establish its reasonable costs on a case-by-case basis under clause (ii), with "reasonable costs" being measured against statutory standards generally.

In a 1985 decision, the Ninth Circuit rejected the Secretary's interpretation of clause (ii) and accepted the interpretation of Mt. Diablo. *Regents of Univ. of California (Davis) v. Heckler*, 771 F.2d 1182 (9th Cir. 1985). The Supreme Court has subsequently ruled, however, that clause (ii) does not authorize retroactive rule-making by the Secretary. *Bowen v. Georgetown Univ. Hospital*, 488 U.S. 204, 109 S.Ct. 468 (1988). As stated earlier, the key issue in this case is thus whether or not the Supreme Court's decision in *Georgetown Univ. Hospital* implicitly overrules the Ninth Circuit's decision in *Regents*.[4]

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[3] The Secretary's interpretation reflects the actual procedure used to reimburse providers for Medicare services. Providers are normally paid in monthly installments, based upon their periodic reports of Medicare costs.

[4] The Supreme Court cited the *Regents* decision for the proposition that the Ninth Circuit had interpreted clause (ii) to require the Secretary to make case-by-case retroactive adjustments to reimbursement determinations, but

A review of these two decision at this juncture is helpful. In *Regents*, Davis Medical Center exceeded the Secretary's Medicare cost limits, and then argued that it was entitled to additional reimbursement beyond the predetermined "reasonable cost" limits on grounds that it had provided atypical nursing services during the relevant reimbursement period for which the Secretary had failed to account. The dispute in *Regents* expressly focused on whether or not Davis Medical Center could challenge the Secretary's methods of cost calculation pursuant to clause (ii). Davis Medical Center argued that the Secretary had a statutory duty under clause (ii) to provide a "retroactive corrective adjustment" whenever the Secretary's methods of cost calculation failed to adequately reimburse a provider for all reasonable costs. The Ninth Circuit accepted this argument, holding that the predetermined cost limits are only presumptive estimates of reasonable costs and that an individual provider has a right to show that, in its particular case, its costs above the limit were reasonable. *Regents*, 771 F.2d at 1192. The court expressly rejected the Secretary's contention that clause (ii) merely authorized a year-end reconciliation between interim payments and aggregate cost limits. *Id.* at 1189. The Court then remanded the case to the Secretary "to (1) review the claimed expenses to determine whether they were, in fact, reasonable, and (2) make such corrective adjustment as may be necessary." *Id.* at 1192.

The *Georgetown Univ. Hospital* case stems from the Secretary's decision in 1981 to amend the existing

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did not expressly overrule it. *Georgetown Univ. Hospital*, 109 S.Ct. at 472 n.1.

wage index used for determining Medicare routine cost limits by adopting a new rule which would exclude the use of data from federal government hospitals. The Secretary's 1981 wage index rule was judicially invalidated on procedural grounds in 1983, and the Secretary thereafter settled the cost reports with provider hospitals using the pre-existing wage index, which included federal government hospitals. Pursuant to this settlement, the Secretary paid additional reimbursements to the provider hospitals. In 1984 the Secretary adopted the previously invalidated 1981 wage index, using proper administrative procedure, and attempted to apply the 1984 rule retroactively to recoup the additional reimbursement amounts previously paid to providers as part of the settlement. In attempting to justify his actions, the Secretary argued before the Supreme Court that retroactive rule-making was authorized by clause (ii), which directs the Secretary to make "retroactive corrective adjustments."

Recognizing that the Secretary had previously interpreted clause (ii) as merely authorizing a year-end balancing of its books, the Supreme Court declined to defer to what it characterized as the Secretary's "convenient litigating position." *Georgetown Univ. Hospital*, 109 S.Ct. at 473-74. Instead, the Supreme Court held that clause (ii) does not authorize retroactive application of new cost-limit rules. Significantly, the Supreme Court reasoned that "nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods." *Id.* at 473 (emphasis in original).

The reasoning of the Supreme Court's decision in *Georgetown Univ. Hospital* compels a conclusion that the Ninth Circuit's interpretation of clause (ii) in *Regents* is no longer viable. Admittedly, the Supreme Court held only that clause (ii) does not authorize retroactive *rule-making*. The Court did not expressly bar providers such as Mt. Diablo from seeking, on a hospital-by-hospital basis, substantive adjustments under clause (ii) for arguably understated reimbursements. Nor did *Georgetown Univ. Hospital* state that the estimated cost limits were absolute rather than presumptive, but for any exceptions to the rule expressly adopted by the Secretary. *See* 42 C.F.R. § 413.30(f). Neither issue was before the Supreme Court, and yet, for the following reasons, the Court's logic inexorably leads to the above conclusions.

Clause (ii) authorizes the Secretary to make "suitable retroactive corrective adjustments" where the aggregate reimbursement "proves to be inadequate or excessive." The Supreme Court in *Georgetown Univ. Hosepital* expressly stated that clause (ii) does not authorize the Secretary to change the methods used to compute costs. *Id.* at 473. It therefore follows that Mt. Diablo in this case cannot challenge the basis for the Secretary's predetermined routine cost limits for 1982 and 1983 under clause (ii).

Mt. Diablo argues that it is not seeking to modify the Secretary's *methods* for calculating the reimbursement cost limits, but rather that these methods produce cost limits that are merely presumptive, and not conclusive, under the Medicare Act. The fallacy of this argument is seen by extending its logic to the factual circumstances of *Georgetown Univ. Hospital*. Clause (ii) applies to adjustments where the aggregate reimbursement is shown to be ". . . either inade-

quate or excessive." This street is two-way. Under Mt. Diablo's interpretation of clause (ii), the Secretary in the *Georgetown Univ. Hospital* scenario could have determined the claimed expenses to be unreasonable and retroactively adjusted such "excessive" payouts on a hospital-by-hospital basis, even after the Supreme Court held that the Secretary was without rule-making authority under clause (ii). Such a result could not have been within the contemplation of the Supreme Court. Case-by-case retroactive adjudication ultimately has the same practical effect as across-the-board retroactive rule-making. Accordingly, Mt. Diablo's reliance on the Ninth Circuit's interpretation of clause (ii) in *Regents* is misplaced. In light of the Supreme Court's holding in *Georgetown Univ. Hospital*, this Court must decline to follow *Regents*.[5]

Other considerations also warrant a narrow interpretation of clause (ii). The Medicare Act expressly provides that "reasonable costs" under the Medicare program "shall be determined in accordance with regulations establishing the method or methods to be used." 42 U.S.C. § 1395x(v)(1)(A). The Secretary's cost limits for 1982 and 1983 were based on such regulations. Mt. Diablo's interpretation of clause (ii) is inconsistent with the statutory framework, because it suggests that reasonable costs should be defined on a hospital-by-hospital and year-by-year basis, rather than by industry-wide regulation. Such an

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[5] While not binding upon this Court, the only appellate court to consider the relationship between *Georgetown Univ. Hospital* and *Regents* reached the same conclusion as the foregoing analysis. *See Hennepin County v. Sullivan*, 883 F.2d 85 (D.C. Cir. 1989). This Court agrees with the reasoning of the *Hennepin* court.

interpretation of clause (ii) not only would create an extraordinarily inefficient and essentially unworkable process for determining the definition of "reasonable costs," but also finds no support elsewhere within the Medicare Act.[6]

Mt. Diablo's interpretation of clause (ii) is also at odds with its legislative history. The purpose of the 1972 Amendments to the Medicare Act was to set cost limits for reimbursement, and thereby reduce escalating Medicare costs by giving providers incentives to operate efficiently. H.R. Rep. No. 231, 92d Cong., 2d Sess. (1972), *reprinted at* 1972 U.S.C. Cong. & Admin. News 4989, 5069. One means of encouraging efficiency was to determine reasonable cost limits prospectively rather than retrospectively, "so that the provider would know in advance the limits to governmental recognition of incurred costs and have an opoprtunity to act to avoid having costs that are not reimbursable." *Id.* at 5070. The Secretary's interpretation of clause (ii) is consistent with this objective, whereas Mt. Diablo's interpretation, which posits a more flexible definition of "reasonable costs," substantially eliminates the incentives for providers to reduce Medicare costs.

For the foregoing reasons, the Court rejects Mt. Diablo's contention that it is entitled to substantive

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[6] The Court also notes that, by its plain language, clause (ii) authorizes the Secretary to make "suitable retroactive corrective adjustments" to cost-limit reimbursements only by promulgating regulations. The language is therefore contrary to Mt. Diablo's interpretation of clause (ii) as permitting case-by-case determinations of what constitutes reasonable costs. Mt. Diablo fails to identify any regulations promulgated pursuant to clause (ii) that support the adjustments it seeks.

retroactive corrective adjustments under clause (ii) because the Secretary's methods of cost calculation for 1982 and 1983 failed to reimburse Mt. Diablo for all of its reasonable costs.

III.

The Court holds that the Secretary's Medicare reimbursement cost limits in 1982 and 1983 were not arbitrary and capricious, as applied to Mt. Diablo, and that plaintiff is not entitled to an adjustment from the cost limits pursuant to 42 U.S.C. § 1395x(v)(1)(A)(ii). Accordingly, the Court DENIES plaintiff's motion for summary judgment and GRANTS defendant's motion for summary judgment.

IT IS SO ORDERED.

DATED: May 24, 1990.

s D. Lowell Jensen
D. LOWELL JENSEN
United States District Judge

APPENDIX E

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-89-2714-DLJ

MT. DIABLO HOSPITAL MEDICAL CENTER, PLAINTIFF

v.

LOUIS SULLIVAN, Secretary of the Department of Health an[d] Human Services, DEFENDANT

Filed May 24, 1990

Entered in Civil Docket 5/30, 1990

JUDGMENT

[Filed May 24, 1990]

For the reasons set forth in the Order issued on this date, the Court ENTERS judgment in favor of defendant.

IT IS SO ORDERED.

DATED: May 24, 1990.

s/ D. Lowell Jensen
D. LOWELL JENSEN
United States District Judge

APPENDIX F

Section 1395x(v)(1)(A) of the Medicare statute, 42 U.S.C. 1395x(v)(1)(A), provides:

> The reasonable costs of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on

estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance program established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance program established under this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

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No. 92-720

In The

Supreme Court of the United States

October Term, 1992

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

MT. DIABLO HOSPITAL MEDICAL CENTER,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE RESPONDENT

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East
Suite 1600
Los Angeles, CA 90067-2799
(310) 551-8165

Attorney for the Respondent Mt. Diablo Hospital Medical Center

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTION PRESENTED

Whether, under the Medicare program, a health care provider may obtain reimbursement under 42 U.S.C. Section 1395x(v)(1)(A)(ii) ("Clause ii") in excess of the cost limits established by the Secretary of the Department of Health and Human Services ("Secretary") even if the provider does not qualify for an exception or exemption under the Secretary's regulations.

LIST OF PARTIES AND RULE 29.1 LIST

The parties to the proceedings below were the Respondent, Mt. Diablo Hospital Medical Center, and Memorial Hospitals Association. Only Mt. Diablo Hospital Medical Center continues to be a party before this Court. Mt. Diablo Hospital Medical Center is a governmental entity, *i.e.*, a district hospital, and thus has no subsidiaries, etc.

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Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 963 F.2d 1175 and is appended to the Secretary's Petition for a Writ of Certiorari at pages 1a-19a. The opinion of the District Court (Pet. App. 24a-39a) and the decision of the Provider Reimbursement Review Board (Pet. App. 21a-23a) are unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on April 28, 1992. A Petition for Rehearing was denied on

July 24, 1992. Pet. App., 20a. The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1).

STATEMENT

The "Statement" contained in the Secretary's Petition for a Writ of Certiorari (at pp. 2-7) is basically accurate. However, additional material facts will have to be discussed upon the briefing of the merits of the case should the Court grant certiorari.

ARGUMENT

While the question presented for review in this case is whether a health care provider may obtain reimbursement under Clause ii in excess of the cost limits established by the Secretary even if the provider does not qualify for an exception or exemption under the Secretary's regulations, that issue will turn largely on the issue of whether the Ninth Circuit's decision in *Regents of the Univ. of California v. Heckler*, 771 F.2d 1182, 1188-92 (9th Cir. 1985), was overruled by this Court in *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). The Ninth Circuit correctly determined in the instant case that *Georgetown* did not overrule *Regents* but rather *Georgetown* cited *Regents* with approval. (Pet. App. 15a-17a.)

This Court has granted certiorari in *Good Samaritan Hosp. v. Sullivan*, 952 F.2d 1017 (8th Cir. 1991), Supreme Court Docket No. 91-2079, to address the issue presented here. Thus, the Secretary asks this Court to "hold" his

petition for a writ of certiorari in this case pending the Court's decision in the *Good Samaritan* case. Respondent Mt. Diablo respectfully submits that the petition should not be held pending resolution of the *Good Samaritan* case, but rather, certiorari should also be granted here to assure that the issue in question is addressed in a sufficient context to avoid continuing confusion over the meaning of this Court's decision in *Georgetown* and *Georgetown's* impact on cases such as the *Regents* case and the instant case.

Respondent Mt. Diablo believes that this case should be briefed and heard together with *Good Samaritan* to assure that the central issue is resolved fully. According to the Eighth Circuit's decision in *Good Samaritan*, the hospitals in that case were "asking for retroactive rule changes, not merely the year-end book balancing allowed in *Georgetown*." The Eighth Circuit characterized the hospitals as "asking this Court to order the Secretary to retroactively adjust cost limits for the number of part-time workers." 952 F.2d at 1024 (*Good Samaritan* Pet. App. at 13a.) If the Eighth Circuit's characterization is correct, then the relief sought by the hospitals in *Good Samaritan* is distinguishable from the relief sought and granted by the Ninth Circuit in Mt. Diablo's case. In addition to seeking to invalidate the cost limits due to the Secretary's failure to consider relevant factors, Mt. Diablo also sought an individualized adjustment to the aggregate amount of its reimbursement under Clause ii, "not [retroactive] revisions in the cost methods used by the Secretary." (Pet. App. at 17a). Significantly, the relief sought and awarded in the *Mt. Diablo* case is the same as that sought and awarded in *Regents*.

Because the relief sought by a provider is critical to the resolution of the issue presented, it is imperative that the Court be presented with a case or cases involving the same relief requested in the *Regents* case since the continued vitality of the *Regents* case has been questioned by the Secretary and affirmed by the Ninth Circuit.

To facilitate the resolution of this case together with the *Good Samaritan* case, Respondent Mt. Diablo is prepared to adhere to the same briefing and oral argument schedule established in the *Good Samaritan* case.

CONCLUSION

Respondent Mt. Diablo agrees that a petition for a writ of certiorari should be granted in this case, however, Mt. Diablo disagrees that this case should be held pending the Court's decision in *Good Samaritan*. Rather, Mt. Diablo respectfully submits that the case should be heard together with the *Good Samaritan* case in order to resolve fully the issue presented.

Respectfully submitted,

PATRIC HOOPER, a Member of
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East
Suite 1600
Los Angeles, CA 90067-2799
(310) 551-8165

Attorney for the Respondent
Mt. Diablo Hospital
Medical Center

October, 1992